

**DO YOU WANT TO FILE A COMPLAINT WITH THE OMBUDSMAN'S OFFICE?**

| Do you need assistance?  | Instructions for Completing this Form  |
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| <p>If your complaint has not been addressed to your satisfaction within the business area you were dealing with at Canada Life, you can submit your complaint to the Ombudsman's Office for a final review.</p> <p><b>Please note: You need to go through the business area's complaint process before submitting your complaint to the Ombudsman's Office.</b> The business area will provide a business decision letter with referral information to the Ombudsman's Office.</p> | <p>This PDF form can be filled electronically using Adobe Reader on your computer. After completing the form on your computer, print and sign and submit by mail, fax or email¹.</p> <p>There are 2 ways to print this form:</p> <ul style="list-style-type: none"> <li>- You can print a blank version of this form to complete manually by selecting the "Print Blank Form" button.</li> <li>- You can print a completed version of this form by selecting the "Print Completed Form" button. This button will indicate any mandatory fields that must be completed before the form can be printed.</li> </ul> |

**If you need help** completing this form or if you have questions:

- ▶ **Contact the Ombudsman's Office** by calling the number listed below, or
- ▶ **Visit our website:** [www.canadalife.com/complaints](http://www.canadalife.com/complaints)
- ▶ **Submitting your complaint:** **THE CANADA LIFE ASSURANCE COMPANY**

|   |  |
|---|--|
| Ombudsman's Office T262<br>255 Dufferin Avenue<br>London ON N6A 4K1 | Phone: 1-866-292-7825<br>Fax: 519-435-7679<br>Email¹: ombudsman@canadalife.com |
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**PART 1 - IDENTIFICATION**

|  |  |   |             |
|--|--|---|-------------|
| Complaint tracking number(s)(required)   | Note: The complaint tracking number was assigned when you first submitted your complaint. You can find this number on any response you have received from us regarding your complaint. |   |             |
| Preferred contact method:<br><input type="checkbox"/> Phone <input type="checkbox"/> Email¹ <input type="checkbox"/> Letter                            | Policy/Plan Number   | ID Number (required for Group plans only) |             |
| Insurance / Product type (e.g. Health & Dental, Disability, Critical Illness, Life Insurance, Investment and Savings, Retirement Income)               |  |   |             |
| <b>Contact information:</b>  |  |   |             |
| <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.<br><input type="checkbox"/> Mr.  | Last name  | First name                                |             |
| Are you the plan member or policy owner? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list owner in the Additional contact section. |  |   |             |
| <b>Address:</b>  |  |   |             |
| No.  | Street   |   | Apt.        |
| City   |  | Province                                  | Postal code |
| Telephone<br><input type="checkbox"/> home <input type="checkbox"/> mobile   | Telephone (work)   | Ext.                                      | Fax         |
|  |  | Email                                     |             |

|   |                  |            |             |
|---|------------------|------------|-------------|
| <b>Additional contact:</b> <input type="checkbox"/> Plan member or policy owner <input type="checkbox"/> Second complainant |                  |            |             |
| <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.<br><input type="checkbox"/> Mr.                                   | Last name        | First name |             |
| Address of additional contact - Check this box if same address: <input type="checkbox"/>                                    |                  |            |             |
| No.   | Street           |            | Apt.        |
| City  |                  | Province   | Postal code |
| Telephone:<br><input type="checkbox"/> home <input type="checkbox"/> mobile   | Telephone (work) | Ext.       | Fax         |
|   |                  | Email      |             |

## PART 2 - DESCRIPTION (Please be as detailed as possible. If you require more space, please add additional pages.)

Why do you disagree with Canada Life's previous decision and/or the handling of your complaint? Why are you dissatisfied with a product or service, or with the response you received?

What resolution are you seeking and why do you feel it is appropriate?

## DOCUMENTS TO ATTACH

1. The business decision letter (this contains information on how to reach the Ombudsman's Office);
2. All relevant documents related to your complaint not previously provided. This might include documents previously requested, new information received including statements, medical reports, etc.

### REMEMBER TO KEEP YOUR ORIGINALS.

After submitting this form, your complaint will be assigned to an Ombudsman Complaint Liaison and their contact information will be provided to you within 5 days of receipt. Complaint reviews normally take up to 30 days to complete. If we need more time, we will let you know. For more information on when the Ombudsman's Office will review a complaint, go to [www.canadalife.com/complaints](http://www.canadalife.com/complaints).

## PERSONAL INFORMATION CONSENT

In order for us to complete a thorough review of your complaint, some or all of the information you provide may be shared with or collected from parties that will be involved in, or who have information relevant to, our review (including parties external to Canada Life where necessary).

By signing below, you consent to Canada Life disclosing and collecting your personal information relevant to this review, including the information contained on this form and any additional information that you supply about your complaint to and from any person who may be involved in the review or who may have information relevant to the review. Information may only be used for the purposes of the review and if the review requires re-assessment of any decision made by Great-West, for that re-assessment. Information may also be shared with our regulators where necessary.

<sup>1</sup> Please note that communications via email over the internet may not be secure. There is a possibility that information you send to us via email can be intercepted and read by other parties besides the party to whom it is intended.

Your signature

Date

Signature of Plan Member/Policy Owner or Second Complainant

Date